Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health and Associates

Respondent Name
WC Solutions

MFDR Tracking Number
M4-13-2138-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management service…"

Amount in Dispute: $28.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions, Inc. maintains the position that the documentation did not support the level of service required to support case management services.".

Response Submitted by: Star Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2012	99361	$28.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for case management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
   - 96 – Per Rule 134(3) – the team conference member shall not be an employee of the coordinating health care provider. All members are within the same practice and billing provider info is the same on all.
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor submit required documentation as required by rule 134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service for date of service 96 – "Per Rule 134(3) – the team conference member shall not be an employee of the coordinating health care provider. All members are within the same practice and billing provider info is the same on all." 28 Texas Labor Code §134.204(e)(4) states in pertinent part, "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity." Review of the submitted documentation finds the following;
    a. Case management note dated 12-5-2012 states, "General Purpose: Care Coordination" "Specific Purpose: Coordinating Care, Developing Treatment Plan" "Outcome: Continue medication management per Dr. Stephenson. Will be referred to Dr Stephenson for injection into the right gracilis and Sartorius distal insertion. Will then be setup with Dr. Glidden for orthopedic evaluation in agreement with the designated doctor examination."

    Review of the submitted documentation finds there is nothing to support "all members are within the same practice…" there is nothing to support the treating physician participated in the case management. The carrier's denial is supported.
2. Requirements of Texas Administrative Code 134.204(e)(3) are not met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.